DEBARTMENT OF HEAT TH AND HUMAN SERVICES

**2**002/011

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	S COD MEDICAR	E & MEDICAID SERVICES				ONB NO	. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES ITATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
alam L Maja mi	099215		B. WING			07/12/2007	
NAME OF PI	ROVIDER OR SUPPLIER		<del>_l</del> .	14	EET ADDREGS, CITY, STATE, ZIP CODE 449 ROXANNA RD, NW (ASHINGTON, DC 20012		
(X4) ID PREFIX TAG	/EARL REGISEN/	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID FREF TAC	ĭX ∣	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
W 000	A initial certification 12, 2007 utilizing male client is current the facility has a collect was diagnor retardation.  The findings of the observation, intermenagement and of administrative include the review system.  This Whollstic Hallocompliance with	LSC IDENTIFYING INPORMATION)		000	DEFICIENCY		
LABORATO	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVES SIG	ANATUR	E _	M TITLE OF	<u></u>	(X6) DATE
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Any deficiency statement ending with an estatisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2587(02-89) Previous Varsione Obsolete

Event ID: DBKY11

Facility ID: 08G215

If continuation sheet Page 1 of 1

Health Regulation Administration

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(X5) DATE SURVEY COMPLETED (X1) PROVIDER/BUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING\_ 07/12/2007 09G215 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1449 ROXANNA RD, NW WHOLISTIC X WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE ID PREFIX (X4) ID (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAĞ DEFICIENCY 1000 LOCO INITIAL COMMENTS A licensure survey was conducted on July 12, 2007. One male ollent is currently residing in the facility and the facility has a capacity for four client. This one client is diagnosed as having mild mental retardation. The findings of this survey were based on observation, Interviews with the facility management and direct care staff and the review of administrative and habilitation records to include the review of unusual incident reporting evetem. 1095 1095 3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation and interview the GHMRP falled to lock caustic agents being storad. 7/15/07 All so caustic and poison agent have been locked. The findings include: During the environmental walk-through on July 12, 2007 at approximately 1:30 PM revealed the following: Caustic agents were being stored in the basement in the laundry area in storage several cabinets which were unlocked. Additionally, a s no bavreedo osla erew atrega otraveo do velra shalf above the washer unlocked and unsecured. 1208 1 208 3509.6 PERSONNEL POLICIES Each employee, prior to employment and Health Regulation Administration (XG) DATE

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

DBKY11

If continuation sheet 1 of 5

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<u>Health R</u>	equiation Administra	ation		т		AM DATE CI	IEVEV
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIE IDENTIFICATION NU  09G215		r/CLIA MBER!	(x2) MULTIPLE CONSTRUCTION  A, BUILDING  B. WING		COMPLETED  O7/12/2007		
	NOMBER OR SUPPLIER	1	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
NAME OF PI	MONDEROITEN	ļ	1449 ROX	ANNA RD, N	IM ·		
WHOLIS	TC X	•	WASHING	TON, DC 20	0012 		
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1 208	Continued From page 1			1208			]
1 400	annually thereafter, shall provide a physician 's certification that a health inventory has been performed and that the employee 's health status would allow him or her to perform the required duties.						
	Based on record rehave on file for revealed failure by of current health or record reference of current health or health or revealed failure by of current health or revealed failure by the current health or record failure fail		illed to intificates ficates y evidence owing:	'	Staff # 1 is no longer in the home. He faile to show up for add Truining. Please Bin Staff # 2 and P.	impael	7/16/07
	- one registered no		,		physicals.		
I 221	Orientation training each GHMRP and amployee 's person	g shall be the respon I shall be documente	sibility of d in each	1 221	•		
	This Statute is no Based on staff into Group Home for M	ot met as evidenced be erview and record rev Mentally Retarded Pe o ensure that all staff	/lew, the reons				
	The finding Includ	lo <b>s</b> :					
	Retardation Profe	facility's Qualified Mossional (QMRP) on J ately 11:30 AM reves	luly 12,				

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Health R	eguietion Administra	atlon	<u> </u>			(X3) DATE SUI	RVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		COMPLETED			
		B. WING			07/12/2007		
		09G215	STREET ADD	RES8, CITY, S	TATE, ZIP CODE	<u> </u>	
NAME OF PROVIDER OR SUPPLIER			ANNA RD, NW				
MHOLIS,				TON, DC 20	012 PROVIDER'S PLAN OF CORREC	TIÓN I	(365)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETE DATE
1 221	Continued From pa	age 2		221			
	the direct care staff #1 was recently employed by the agency. Review of the available training manual failed to reflect that staff #1 had participated in orientation training prior to or after employment as required by the agency's policies.			1 227	Stoff # 1the been terming for failure to aftend truining pursuant to the POC. All Sight in how	املاط ان	7/22/07
1 227	3510.5(d) STAFF TRAINING  Each training program shall include, but not be limited to, the following:			,,	have been trained		
	(c) Infection control for shaff and residents;						
	Based on observations are recognized signs at	of met as evidenced be ation, staff interview a falled to affectively true of illnessures for cility.	nd record Bin Staff to Band				
]	The findings inclu	The findings include:					
	Professional (QM approximately 1:0 the staffing sched Record review on Staff #1 and Staff certifications.  2. Interview with the approximately 1:0 the staffing sched Record review on Record review on the staffing sched	he Qualified Mental R RP) on July 12, 2007 10 AM revealed that a lule was not trained in July 12, 2007 reveal the QMRP on July 12, 10 AM revealed that a dule was not trained in July 12, 2007 reveal that a dule was not trained in July 12, 2007 reveal of #3 did not have curre	at ij staff on i CPR. ed that ent CPR , 2007 at ill staff on a First Ald. ed that		Staff 1 is nolonger in home. Staff # 3 ha Current CPR + First A Please bind attached	5d	7/16/07
		<u> </u>					

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H <u>ealth R</u>	<u>Requiation Administr</u>	ration		7		ON DATE C	JEV/EV
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  (21) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (32) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBÉR:	(x2) MULTIPLE CONSTRUCTION A. BUILDING		(XB) DATE SURVEY COMPLETED	
			B. WING_		07/12	/2007	
NAME OF P	ROVIDER OR SUPPLIER			DRESS, CITY, 6 LANNA RD, I	STATE, ZIP CODE		
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R 000	INITIAL COMMEN	TS		R 000			
	2007. One male of	was conducted on Judient is currently residually has a capacity for ent is diagnosed with	iing in the i Four			,	
	observation, intentional management and of administrative a	is survey were based views with the facility direct care staff and t and habilitation record of unusual incident n	the review		•		
R 125	4701,5 BACKGR	OUND CHECK REQU	IREMENT	R 125			
	criminal history of contract worker to in all jurisdictions employee of contract.	ground check shall di the prospective emplor the previous seven within which the pros ract worker has works seven (7) years prior	loyee of (7) years, pective ad or				
	Based on the revi falled to ensure c the previous seve	ot met as evidenced b lew of records, the Gi riminal background ci an (7) years, in all juris I or resided within the	HMRP nacks for sdictions				,
	The finding includ	ies:			ا أ ف الناسيم الم	a.c c.	
	approximately 12	rsonnel files on July 1 :30 PM revealed the 0 s oriminal background taff #1.	SHMRP		Stuff #1 is not long home for failure to puisuant to this P slutt have crimas checks.	alteral training	7 1007
Health Reg	rulation Administration	atte There	,		TITLE		(X6) DATE
LABORATO	~/ / √ RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESE	NTATIVE'S SI	GNATURE	Via Preside	+ 7	124/07